

**SOUTH DAKOTA BOARD OF EXAMINERS FOR NURSING FACILITY  
ADMINISTRATORS  
INITIAL RECIPROCITY APPLICATION  
TO ESTABLISH ELIGIBILITY FOR LICENSURE**

NAME: _____ <small>(Please Print)</small>		SOC SEC NO: _____	
HOME ADDRESS: _____ <div style="display: flex; justify-content: space-between;"><span>Street</span><span>City</span><span>ST</span><span>Zip Code</span></div>			
TELEPHONE NUMBER: _____ <div style="display: flex; justify-content: space-between;"><span>(Home)</span><span>(Work)</span></div>			
DATE OF BIRTH: _____			
FACILITY NAME: _____			
ADDRESS: _____ <div style="display: flex; justify-content: space-between;"><span>Street</span><span>City</span><span>ST</span><span>Zip Code</span></div>			
Circle Employment Status:	Full-Time?	Part-Time?	
Circle Gender Type:	Male?	Female?	

**Every applicant for a nursing facility administrator's license is required to submit the following with his/her application:**

- 1) \$100.00 initial application fee. An additional fee will be required for writing the state test.  
*(Application fee is non-refundable.)*
- 2) Copy of Administrator's License in the state you are currently licensed.
- 3) I am / am not (CIRCLE ONE) currently \$1,000 or more behind in child support payments?
- 4) I have / have not (CIRCLE ONE) ever been convicted of, pled guilty to, or pled no contest to, an offense that could have resulted in incarceration for more than a year.

If yes, please explain on a separate sheet of paper.

*I declare and affirm under the penalties of perjury that this application has been examined by me, and to the best of my knowledge and belief, is in all things true and correct. I am aware that any misstatements of material facts may cause rejection of my application. I have no objection to inquiries being made for the purpose verifying the statements made herein.*

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

Sworn to and before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Notary Signature

My commission expires:  
(seal)

Please return this **notarized** application and your non-refundable \$100 **check** payable to:  
**SD Board of Examiners for NFA, PO Box 632, Sioux Falls, SD 57101-0632**

# **CERTIFICATION BY SECRETARY OF STATE BOARD**

(To be completed by the State that issued applicant's current, active license.)

## **PERSONAL INFO**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

## **LICENSE INFO**

LICENSE NUMBER: \_\_\_\_\_ ISSUE DATE: \_\_\_\_\_

EXPIRATION DATE: \_\_\_\_\_

Status of License: Active: \_\_\_\_\_ Inactive: \_\_\_\_\_ Expired: \_\_\_\_\_

Exam Score: Type: NAB \_\_\_\_\_ PES \_\_\_\_\_ Other \_\_\_\_\_

Raw Score: \_\_\_\_\_

Scale Score: \_\_\_\_\_

Examination State: \_\_\_\_\_

Date of Exam: \_\_\_\_\_

Was the applicant required to complete an AIT or practicum? \_\_\_\_\_ yes \_\_\_\_\_ no

If yes, how long was the AIT or practicum? \_\_\_\_\_

Has the applicant been a practicing administrator in your state for at least 6 months? \_\_\_\_\_ yes  
\_\_\_\_\_ no

Has the applicant ever been disciplined or investigated by the Board? \_\_\_\_\_ yes \_\_\_\_\_ no

If yes, please explain: \_\_\_\_\_

*Acting on behalf of the \_\_\_\_\_ State Board of Examiners for Nursing Facility Administrators, I hereby certify to the reputability of \_\_\_\_\_ based on the records of this Board, and recommend him/her to the South Dakota Board of Examiners for Nursing Facility Administrators as a fit and proper person to receive a license to serve as a Nursing Facility Administrator.*

Return to:  
SD Board of Examiners for NFA  
PO Box 632  
Sioux Falls, SD 57101-0632

State Seal

\_\_\_\_\_  
(Secretary of State Licensing Board)

\_\_\_\_\_  
(Name of Board)

\_\_\_\_\_  
(Address)